| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155251 | A. BUILDING _____ B. WING _____ | C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER'S MERRY MANOR | 2901 W 37TH AVE HOBART, IN 46342 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00181441.<br><br>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00179470 and IN00179997 completed on August 19, 2015.<br><br>Complaint IN00181441- Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey date:<br>September 24, 2015<br><br>Facility number: 000154<br>Provider number: 155251<br>AIM number: 100289680<br><br>Census bed type:<br>SNF: 14<br>SNF/NF: 65<br>Total: 79<br><br>Census payor type:<br>Medicare: 14<br>Medicaid: 56<br>Other: 9<br>Total: 79<br><br>Sample: 10<br><br>Millers Merry Manor was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00181441.<br><br>Quality review completed by 26143, on | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **MILLER'S MERRY MANOR** | **2901 W 37TH AVE HOBART, IN 46342** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br>September 27, 2015.<br>. | F 000 | | |